MCO
GENERAL
AMENDMENT

CONTRACTS
16 - 20

(General)**AMENDMENT NUMBER 12**

AMENDED AND RESTATED CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
CONTRACTOR NAME,
d.b.a.

CONTRACT NUMBER: FA-

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Contractor Name, hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-3 shall be amended by adding a definition for "Intervention".

   Intervention - An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

2. Section 2-2.1 shall be deleted and replaced as follows:

   2-2.1. Agree to report all provider related data required pursuant to this Agreement to TENNCARE using uniform provider numbers. The uniform numbers to be reported for all providers except pharmacy will be the National Provider Identifier (NPI) Number issued by CMS where applicable, and the traditional "Medicaid" provider number issued by TENNCARE. Prior to payment of a claim, the MCO shall require that providers that have not been enrolled in the TennCare Program previously as a Medicaid provider or as a provider who currently receives direct payment from TENNCARE (i.e., Medicare cost sharing) contact the Medicaid/TennCare Provider Enrollment Unit and obtain a "Medicaid" provider number. The issuance of a "Medicaid" provider number by TennCare is simply for the purpose of establishing a common provider number for reporting purposes as required by this Section and does not imply that TENNCARE has credentialed the provider or convey any other contractual relationship or any other responsibility with the provider. Pharmacy providers shall use the National Association Board of Pharmacy (NABP) number that has been assigned as well as the NPI number issued by CMS where applicable. The CONTRACTOR agrees to utilize CMS's newly established NPI numbers for all provider reporting purposes in accordance with timeframes established by CMS, including but not limited to, the development of contingency plans, beginning May 23, 2007 and the implementation of final plans thereafter;

3. Section 2-3.b.1 and 2 shall be deleted and replaced as follows:

   2-3.b.1. Primary Care Providers (PCPs)

   (a) With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1-3, who is responsible for coordinating the covered services provided to the member.

(b) The CONTRACTOR shall assure that there are PCPs, willing and able to provide the level of care and range of services necessary to meet the medical needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the Terms and Conditions for Access provided in Attachment III.

(c) The CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.

(d) The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP as defined in Section 1-3.

(e) If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.

(f) The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR must include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.

(g) If a member requests assignment to a PCP located outside the distance/time requirements in Attachment III and the CONTRACTOR has PCPs available within the distance/time requirements who accept new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider. In these cases, the CONTRACTOR must allow the member to change assignment to a PCP within the distance/time requirements at any time if the member requests such a change.

2-3.b.2. Specialty Service Providers

(1) Essential Hospital Services and Centers of Excellence

(a) The CONTRACTOR shall demonstrate sufficient access to Essential Hospital Services which means that, at a minimum, in each Grand Region served by the CONTRACTOR, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) tertiary care center for each of the following:

(i) neonatal services;
(ii) perinatal services;

(iii) pediatric services;
(iv) trauma services; and
(v) burn services.

(b) The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that, at a minimum, in each Grand Region in which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region(s). HIV/AIDS centers of Excellence are designated by the DOH.

(2) Physician Specialists

The CONTRACTOR shall establish and maintain a network of physician specialist that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the health care needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

(a) The CONTRACTOR has signed provider agreements with providers of the specialty types listed in Attachment IV who accept new TennCare enrollees and are available on at least a referral basis; and

(b) The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, and IV.

(3) TENNCARE Monitoring

TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section 2-10.c.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.

(a) TENNCARE will require a corrective action plan from the CONTRACTOR when:

(i) Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;

(ii) Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or

(iii) The member to provider ratio exceeds that listed in Attachment IV.

(b) TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective

action plan will be accepted. Corrective action plans shall include, at a minimum, the following:

(i) The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;

(ii) A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;

(iii) For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;

(iv) A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;

(iv) Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;

(v) Documentation of how these arrangements are communicated to the member; and

(vi) Documentation of how these arrangements are communicated to the PCPs.

(4) Weight Watchers

The CONTRACTOR shall include in its network the Weight Watchers regional center in the Grand Region(s) in which the CONTRACTOR operates.

4. Section 2-3.c.5 shall be deleted and replaced as follows:

2-3.c.5 Coordination with the Department of Education

The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers and the Department of Health's Project Teach staff to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for

payment. The CONTRACTOR must designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the MCO must:

(a) Either accept the IEP as indication of a medical problem and treat the IEP as a request for service authorization and assist, if necessary, in making an appointment to have the child evaluated by the child's PCP or another in-network provider in accordance with the time frames specified in the TennCare Waiver Terms and Conditions for access to care.

(b) Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

(c) Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery).

5. Section 2-3.o.3(c) shall be amended by adding a new sentence to the end of the existing text.

2-3.o.3(c) The individual or her authorized representative, if any, must sign and date a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form, contained in this Agreement as Attachment VII, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with Federal requirements. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary. See attached form and instructions for additional guidance and exceptions.

6. Section 2-3.s.2 shall be amended by deleting and replacing "Monitoring of outcomes." In Section 2-3.s.2(a) with "Program Evaluation." and adding a new Section 2-3.s.2(g) and (h) which shall read as follows:

2. MCO Case Management

(a) The CONTRACTOR shall maintain an MCO case management program that includes the following components:

(1) A systematic approach to identify eligible members;
(2) Assessment of member needs;
(3) Development of an individualized plan of care;
(4) Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
(5) Program Evaluation.

(g) The CONTRACTOR shall submit a quarterly case management report in a format prescribed by TENNCARE. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management services.

(h) By August 15, 2007, the CONTRACTOR will submit a report to TENNCARE describing the CONTRACTOR's case management services. The report will include a description of the criteria and process the CONTRACTOR uses to identify members for case management, the process the CONTRACTOR uses to inform members and providers of the availability of case management, a description of the case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its case management program. Annually thereafter, the CONTRACTOR shall submit a report outlining any changes to the case management program,

along with justification for such changes. These reports should only contain case management activity.

7. Section 2-3.s.5 shall be deleted and replaced as follows:

2-3.s.5. Excessive and/or Inappropriate Emergency Department (ED) Utilization. The CONTRACTOR shall utilize the following guidelines in identifying and managing care for enrollees who are determined to have excessive and/or inappropriate ED utilization.

(a) Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify enrollees with utilization exceeding a threshold defined by TENNCARE in the preceding six (6) month period. In January, review ED utilization during the preceding April through September. In July review ED utilization during the preceding October through March. A report shall be submitted to TENNCARE no later than February 28th and August 31st each year identifying enrollees who exceeded the defined threshold for ED usage and specifying the interventions initiated for each enrollee.

(b) Enroll in active case management – (Enrollees who exceed a specified number, to be defined by TENNCARE, of ED visits in the previous six (6) month period)

(c) Make contact with enrollee and primary care provider

(d) Review encounter data

(e) Assess most likely cause of problem (e.g., drug seeking behavior, primary care/access problem, poorly controlled disease state, etc.)

(f) Develop a case management plan based on results of the assessment. Sample plans based on potential assessment results follow:

(1) Drug seeking behavior

i. Interact with TennCare Pharmacy Division regarding possibility of pharmacy lock-in and/or controlled substance prior authorization requirement

ii. Contact all providers regarding concern that patient may be abusing prescription medications

iii. Make appropriate referrals (e.g., OIG, Pain clinic, Substance abuse treatment program, etc.)

iv. Consider primary care provider lock-in (i.e. patient must have PCP approval before he/she can access other providers)

(2) Primary Care /Access Problem

i. Change PCP and/or address problem with current PCP

ii. Provide enrollee education regarding appropriate use of PCP and ED

iii. Provide access to a 1-800 customer service line for assistance identifying and selecting a PCP and to the extent necessary, assistance scheduling an appointment with PCP

(3) Poorly controlled disease

i. Enroll in disease management

ii. Refer to specialist for management – advise PCP

iii. Provide access to 1-800 24/7 nurse answered line capable of providing health information/education to patients; healthcare counseling/telephone triage to assess health status to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings.

(g) Any blanket policy to deny payment for specified "non-emergency" services in the ED based on diagnoses must be accompanied by the following guidelines.

(1) Clear communication to all hospitals/EDs regarding the diagnoses that are and are not considered emergencies;

(2) A process whereby the hospital could demonstrate that a condition on the list did, in fact, represent an emergency;

(3) Clear communication to all hospitals/EDs regarding the mechanism to bill for the EMTALA required screen associated with any non-emergency diagnoses;

(4) Payment for the EMTALA screens associated with any non-emergency diagnosis, and

(5) A specific process that the MCO shares with all hospitals/EDs by which the ED can contact the MCO 24/7 to refer an enrollee with one of the non-emergency diagnoses to the MCO for assistance in arranging for care in an alternative setting, when such assistance is requested by the member.

(h) For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the MCO must have a specific process in place whereby the ED can contact the MCO 24/7 via a toll free phone line to obtain assistance for enrollees with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 Nurse Triage line described at Section 2-9.c.8 of this Agreement for this purpose or may use another line the CONTRACTOR designates. By August 1, 2007, the CONTRACTOR must submit a written report to TENNCARE providing the telephone number that will be used for such scheduling assistance and describing the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line. (i) If the CONTRACTOR chooses to implement a blanket policy as identified in subsection (g) above, failure to comply with the ED guidelines as described therein may result in liquidated damages as described in Section 4-8.b.2 of this Agreement.

j) The CONTRACTOR shall track and report on a quarterly basis, the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report will include the date and time of the call, identifying information for the enrollee, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the Nurse Triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2-9.c.8 of this Agreement.

8. Section 2-3.s.6(e) shall be deleted and replaced as follows:

(e) CONTRACTOR's Program Description

The CONTRACTOR shall submit a description of it's Disease Management Program on an annual basis in accordance with Section 2-10.m.7(b).

9. Section 2-3.s.6(h) shall be deleted and replaced as follows:

(h) Program Evaluation (Satisfaction and Effectiveness)
The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction must be specific to DM programs. A written summary, of member satisfaction with the DM program, shall be included in the annual DM report.

The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include the following information. This

information shall be reported to TENNCARE annually on July 1st in accordance with Section 2-10.m.7.

1. The total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required DM programs;
2. The passive participation rate (as defined by NCQA) for each of the required DM programs, including the numerator and denominator used in calculating the rate
3. The number of individuals participating in each level or stratification of each of the DM programs;
4. Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
5. The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
6. Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
7. HEDIS measures related to any of the four DM projects;
8. Member adherence to treatment plans;
9. Provider adherence to the guidelines; and
10. Any other performance measure associated with any of the four DM programs that the MCO has chosen to track.

10. Section 2-3.s.7 shall be amended by adding additional text.

7. Disease Management for Obesity. In addition to the aforementioned disease management requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2-3.h). This DM program shall, at a minimum, fulfill all requirements related to the TennCare Partnership with Weight Watchers program. This means that, at a minimum, the CONTRACTOR shall have provider agreements with the appropriate Weight Watchers regional center(s); educate its contract providers about the program to ensure they make appropriate referrals for members; and process claims according to the requirements in Section 2-9.m.

11. Section 2-3.u.7(a) shall be amended by adding a new Section 2-3.u.7(a)4.

4. MCOs must have the ability to conduct EPSDT outreach in formats appropriate to enrollees who are blind, deaf, illiterate or non-English speaking. At least one of the 6 outreach attempts identified above must advise enrollees regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

12. Section 2-3.u.7(b) and (c) shall be deleted and replaced as follows:

(b) The CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. The MCO must have a mechanism for maintaining records of efforts made to reach out to children who have missed screening appointments or who have failed to receive regular check-ups. The MCO must make at least one effort each quarter to get such children in for a screening. These efforts are in addition to the efforts described in Section 2-3.u.7 (a) above and must be a different written or oral strategy each quarter. It will not be adequate to simply send the same letter four times.

(c) The MCO must have a process for determining if someone eligible for EPSDT has used no services within a year. The MCO must make two reasonable attempts to re-notify such members about EPSDT. One of these attempts can be to refer the member/family to the local health department for a screen. (These two attempts are in addition to the one attempt per quarter mentioned above.)

13. Section 2-5.b.2 shall be deleted and replaced as follows:

2-5.b.2. Quarterly Newsletters

(a) **General Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The CONTRACTOR shall include the following information in each newsletter:

(1) specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included; and

(2) the procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

(3) a notice to enrollees of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E.. 97-35), and a Contractor phone number for doing so. The notice shall be in English and Spanish;

(4) for TennCare enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services;

(5) member services toll free telephone numbers; including the TennCare Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line as well as the service/information that may be obtained from each line; and

(6) the following information to report fraud: "To report fraud or abuse to OIG: You can call free 1-800-433-3982 OR Go online at www.state.tn.us/tenncare and click on "Report Fraud." To report provider fraud or patient abuse to MFCU, call free 1-800-433-5454."

(b) **Teen/Adolescent Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved by TENNCARE.

The CONTRACTOR shall include the following information in each newsletter:

(a) Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and

(b) The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

(c) TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.

In order to satisfy the requirement to distribute the quarterly newsletters to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollee's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating that the newsletters were mailed within the calendar quarter, the quantity, and the date mailed, to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 4-8 of this Agreement.

14. Section 2-6.a.12 shall be amended by adding new text in the last paragraph so that the amended Section 2-6.a.12 shall read as follows:

2-6.a. 12. It is the intent and policy of TENNCARE that TennCare-eligible newborn children and their Mothers, to the extent that the Mother is eligible for TennCare, be enrolled in the same CONTRACTOR health plan with the exception of children that are SSI eligible at birth. Children that are SSI eligible at birth shall be assigned to TennCare Select. Enrollment of the newborn child in the same plan as its Mother facilitates coverage and payment of the costs associated with delivery, facilitates coverage and payment of the newborn services provided after birth of the child but prior to establishment of individual TennCare eligibility for the child and provides a financial incentive to the CONTRACTOR to promote prenatal care as a means to reduce the risks of a complicated and more costly pregnancy and/or delivery.

It is recognized by TENNCARE and the CONTRACTOR that despite the best efforts of TENNCARE to assure enrollment of a newborn in the same plan as its Mother, due to the various means of enrollment in the TennCare Program, a newborn child may be inadvertently enrolled in a plan different than its Mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn child has been incorrectly enrolled in a plan different than its Mother. Upon receipt of such notice from a CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in a plan different than its Mother, TENNCARE shall immediately:

(a) Disenroll the newborn from the incorrect plan;
(b) Recoup any fixed administrative rate payments made to the CONTRACTOR for the newborn;
(c) Enroll the newborn in the same plan as its Mother with the same effective date as when the newborn child was enrolled in the incorrect plan; and
(d) Make fixed administrative rate payments to the correct plan for the period of coverage.

The plan in which the newborn child is correctly enrolled shall be responsible for the coverage and payment of TennCare-covered services provided to the newborn child for the full period of eligibility. The plan in which the newborn child was incorrectly enrolled shall have no liability for the coverage or payment of any TennCare-covered services provided, except as described below, during the period of incorrect plan assignment and TENNCARE shall have no liability for payment of the fixed administrative rate or payments for covered services to the CONTRACTOR in these cases.

There are circumstances in which a newborn child's Mother may not be eligible for participation in the TennCare program. Each CONTRACTOR shall be required to

process claims received for services provided to newborn children within the time frames specified in Section 2-9.m of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn child, during any period of enrollment in the CONTRACTOR's plan, because the child's Mother is not a member of the CONTRACTOR's plan. However, it is recognized that in complying with the claims processing time frames specified in Section 2-9.m of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn child enrolled in the CONTRACTOR's plan at the time of payment but the child's eligibility may subsequently be moved to another contractor's plan. In such event, the CONTRACTOR in which the newborn child is first enrolled (first plan) may submit supporting documentation to the contractor's plan in which the newborn child is moved (second plan) and the second plan shall reimburse the first plan within thirty (30) days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the child prior to the child's eligibility having been moved to the second plan. Such reimbursement shall be the actual amount expended by the first plan. The second plan agrees that should the second plan fail to reimburse the first plan the actual amount expended on behalf of the newborn child within thirty (30) days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second plan and to reimburse the first plan. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 4-8.b.2. Should it become necessary for TENNCARE to intervene in such cases, both the second plan and the first plan agree that TENNCARE shall be held harmless by both plans for actions taken to resolve the dispute.

15. Section 2-9.c.8 shall be amended by adding additional text to the end of existing text.

2-9.c.8. The CONTRACTOR shall maintain a 1-800 Nurse Triage line that shall be available to members 24 hours a day, seven days a week. The 24/7 Nurse Triage line service shall provide health information/education to patients; healthcare counseling/telephone triage to assess health status in order to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings. The CONTRACTOR shall include information on the Nurse Triage line, including the telephone number and the services/information available by calling the line, in the member handbook and in quarterly member newsletters. The CONTRACTOR shall track and report on a quarterly basis total calls received by the 24/7 Nurse Triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2-3.s.5 (h) of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-3.s.5 (j) of this Agreement.

16. Section 2-9.j.2 and 2-9.j.3 and 2-9.j.7 shall be deleted and replaced as follows:

2-9.j.2. Clinical and Service Quality Improvement/Performance Improvement Activities

The CONTRACTOR shall perform three (3) clinical and two (2) service quality improvement activities relevant to the enrollee population. These Quality Improvement Activities may be used to meet NCQA requirements if applicable. Two of the three clinical activities shall be determined by TENNCARE. The TENNCARE selected clinical quality improvement activity topics are

diabetes and maternity management. The following must be documented for each activity and CMS protocols for performance improvements projects (PIPs) must be met:

- Rationale for selection as a quality improvement activity
- Specific population targeted, include sampling methodology if relevant
- Metrics to determine meaningful improvement and baseline measurement
- Specific interventions (enrollee and provider)
- Relevant clinical practice guidelines
- Date of re-measurement

The CONTRACTOR shall electronically submit Quality Improvement Activity Forms as required by NCQA. These forms are available at www.NCQA.org.

2-9.j.3. Clinical Practice Guidelines

The CONTRACTOR shall select at least four (4) evidence-based clinical practice guidelines from recognized sources that are relevant to the enrollee population. Guidelines must be distributed to all appropriate providers. The MCO shall measure performance against at least two (2) important aspects of each of the four (4) clinical practice guidelines annually. The guidelines must be reviewed and any revisions distributed to appropriate providers at least every two (2) years or whenever national guidelines change. The CONTRACTOR must submit the names of the clinical guidelines (ADA, AMA, etc.) along with a report on the results of performance measures utilized for each.

2-9.j.7 NCQA Accreditation

NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. In order to assure that the CONTRACTOR is making forward progress, TENNCARE shall require the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2005	
Submit preliminary HEDIS data to EQRO as required by the CRA	July 1, 2005
Submit locked DST to NCQA	July 15, 2005
Purchase NCQA ISS Tool for 2006 MCO Accreditation Survey	August 1, 2005
Utilize the NCQA approved Quality Improvement Activity Form to submit baseline data, barrier analysis, and planned interventions for three (3) Clinical and two (2) Service Improvement Studies selected by MCO.	September 15, 2005
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 CAHPS Survey to TENNCARE	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 HEDIS Audit to TENNCARE	November 15, 2005
Submit copy of signed NCQA Survey Contract to TENNCARE	December 15, 2005
Notify TennCare of date for ISS Submission and NCQA Onsite review	December 31, 2005
CALENDAR YEAR 2006	
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor and TennCare	February 15, 2006
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and	June 15, 2006

TennCare	
Finalize preparations for NCQA Survey (final payment must be submitted to NCQA 60 days prior to submission of ISS.	July 1 – September 15, 2006
Submit ISS to NCQA	No later than September 18, 2006
NCQA Survey Completed and copy of NCQA Final Report to TennCare: • Excellent, Commendable, or Accredited • Provisional – Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within 12 months. Plan of Corrective Action addressing deficiencies noted by NCQA to TennCare within thirty (30) days of receipt of Final Report from NCQA. Provisional status may result in the assessment of liquidated damages or termination of this Agreement. • Accreditation Denied – Results in termination of this Agreement	December 31, 2006
CALENDAR YEAR 2007	
Complete NCQA Reconsideration Process (if necessary)	January 1, 2007-March 30, 2007
Complete Provisional NCQA Accreditation Resurvey NOTE: Provisional NCQA Accreditation may result in the assessment of liquidated damages or termination of this Agreement	December 31, 2007
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2007
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA
CALENDAR YEAR 2008	
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS* results submitted to NCQA and TennCare and the EQRO	June 15, 2008
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA

* Annually, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TennCare, separately for each required CAHPS survey

The CONTRACTOR may obtain additional payments for the successful achievement of NCQA Accreditation as described in Section 3-10.i.10 of this Agreement.

If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Agreement and may be subject to termination in accordance with Section 4-2.b of this Agreement. Further, failure to achieve specified benchmarks or reporting requirements, as described in Section 4-8.b.2 shall result in damages as described therein.

Failure to obtain NCQA Accreditation by December 31, 2006 and maintain Accreditation thereafter, shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 4-2.b of this Agreement. Achievement of Provisional accreditation status shall require a corrective action plan and may result in termination of this Agreement.

Following accreditation or re-accreditation, the CONTRACTOR must submit a copy of the bound report from NCQA" within 10 days of receipt of the report. The report from the accreditation process conducted in 2006 will be within 10 days of signature of this Agreement or within 10 days of receipt from NCQA which ever occurs later.

17. Section 2-9.n.6(c)(3) shall be amended by adding additional text as follows:

(3) Emergency Room Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee emergency room utilization by PCP panel and provide a report to TENNCARE as described in Section 2-10.p.2 of this Agreement. Individual enrollees who establish a pattern of accessing emergency room services should be referred to case management for follow-up.

18. Section 2-10.c.1 shall be amended by adding additional text as follows:

2-10.c.1. Monthly Provider Enrollment File

The CONTRACTOR shall furnish to TENNCARE at the beginning of the Agreement period an electronic report in the format specified by TENNCARE listing all providers enrolled in the TennCare plan, including but not limited to, physicians, dentists, hospitals, home health agencies, pharmacies, medical vendors, ambulance, etc. This listing shall include regularly enrolled providers, specialty or referral providers and any other provider, which may be enrolled for purposes of payment for services provided out-of-plan. The minimum data elements required for all provider listings required in this Section may be found in Attachment XII, Exhibit C of this Agreement. The CONTRACTOR shall be required to inquire as to the provider's race and/or national origin and shall report to TENNCARE the information, if any, furnished by the provider in response to such an inquiry. The CONTRACTOR shall be prohibited from requiring the provider to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

Thereafter, a complete electronic provider replacement file (full file refresh) shall be submitted on a monthly basis by the 5th of each month. This information shall be used to determine CONTRACTOR compliance with network adequacy standards and shall be used in conjunction with encounter data.

Each provider shall be identified by a Tennessee Medicaid I.D. number (i.e., each servicing provider in a group or clinic practice must be identified by a separate provider number) as well as the National Provider Identifier (NPI) Number, effective May 23, 2007. These unique identifiers shall appear on all encounter data transmittals.

Within ten (10) working days of a request by TENNCARE, the CONTRACTOR shall provide an unduplicated listing of all contracting providers, in a format designated by TENNCARE.

Failure to report the provider information, as specified above, shall result in the application of liquidated damages as described in Section 4-8 of this Agreement.

19. Section 2-10.e.4 shall be deleted in its entirety.

20. Section 2-10.m.3 shall be deleted and replaced as follows:

2-10.m.3. PCP Assignment

The CONTRACTOR shall submit a quarterly report to TENNCARE by PCP that shall include the following information for non-dual populations: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following; Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +.

21. Section 2-10.m.7 shall be deleted and replaced as follows:

2-10.m.7. Disease Management Evaluation

(a) The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program as described in Section 2-3.s.6, a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall be submitted in a format prescribed by TENNCARE.

(b) Annually on July 1st, the CONTRACTOR shall submit a *Disease Management Report* that includes, the following:

(1) Definition of target population (eligibility criteria) for each program and the method used to identify and enroll members including frequency of systematic identification process;

(2) Written description of the stratification levels for each of the four (4) programs , including member criteria and associated interventions;

(3) Information specified in 2-3.s.6 (g);

(4) Written analysis of data presented;

(5) Discussion of barriers and challenges to include resources, program structure, member involvement and provider participation;

(6) Summary of member satisfaction with the DM program; and

(7) Description of proposed changes to program based on evaluation.

22. Section 2-10.m. shall be amended by adding a new Section 2-10.m.9 which shall read as follows:

2-10.m(9) Case Management Reporting

(1) The CONTRACTOR shall submit a quarterly case management report in a format prescribed by TENNCARE. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management services.

(2) By August 15, 2007, the CONTRACTOR will submit a report to TENNCARE describing the CONTRACTOR's case management services. The report will include a description of the criteria and process the CONTRACTOR uses to identify members for case management, the process the CONTRACTOR uses to inform members and providers of the availability of case management, a description of the case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its case management program. Annually thereafter, the CONTRACTOR shall submit a report outlining any changes to the case management program, along with justification for such changes. These reports should only contain case management activity.

23. Section 2-10.n.7 shall be amended by adding additional text as follows:

2-10.n.7 High-Cost Claimants

The CONTRACTOR shall identify and report to TennCare the number of enrollees who incurred claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis. The CONTRACTOR shall report the enrollee's age, sex, primary diagnosis, and amount paid by claim type for each enrollee. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.

24. Section 2-10.p. shall be deleted and replaced as follows:

2-10.p. Network Management

2-10.p.1 PCP Visits

The CONTRACTOR shall submit a quarterly *PCP Visits Per Member Per Year Report* in the format prescribed by TENNCARE. The number of PCP visits per member during the reporting quarter shall be projected to reflect a twelve (12) month period.

2-10.p.2 Out-of-Network Utilization

As specified in Section 2-9.n, the CONTRACTOR shall maintain a procedure to identify enrollees by PCP panel who establish a pattern of utilizing non-network providers. Management reports designed to support this requirement shall be submitted to the state on a quarterly basis.

2-10.p.3 Emergency Room Utilization

As specified in Sections 2-3.s.5 and 2-9.n, the CONTRACTOR shall maintain a procedure to identify enrollees by PCP panel who establish a pattern of use of the emergency room and shall submit the following reports regarding Emergency Room/Emergency Department Utilization.

(a) The CONTRACTOR shall submit a monthly report by PCP that includes the following information: Provider Name, Provider Medicaid I.D. Number, NPI Number, Provider Specialty, Number of Members assigned, and Number of ER Visits. This report shall include a rolling twelve (12) months which shall be refreshed on a monthly basis and submitted with a thirty (30) day lag. Each monthly report is due to TENNCARE by the 5th calendar day of the following month.

(b) In accordance with Section 2-3.s.5, the CONTRACTOR shall submit to TENNCARE the following Emergency Department Utilization Reports:

(1) No later than February 28th and August 31st each year, submit a report identifying enrollees who exceeded the defined threshold for ED usage and specifying the interventions initiated for each enrollee.

(2) By August 1, 2007, the CONTRACTOR must submit a written report to TENNCARE providing the telephone number that will be used for such scheduling assistance and describing the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line.

(3) On a quarterly basis, the CONTRACTOR shall report the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report will include the date and time of the call, identifying information for the enrollee, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the Nurse Triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2-9.c.8 of this Agreement.

2-10.p.4 Specialty Utilization

As specified in Section 2-9.n, the CONTRACTOR shall maintain a procedure to identify utilization of specialists by Primary Care Provider enrollee panel. Management reports designed to support this requirement shall be submitted to the state on a quarterly basis.

2-10.p.5 **24/7** Nurse Triage Call Line

In accordance with Section 2-9.c.8 of this Agreement, the CONTRACTOR shall track and report on a quarterly basis total calls received by the 24/7 Nurse Triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2-3.s.5 (h) of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-3.s.5 (j) of this Agreement

25. Section 3-10.i.2 shall be deleted and replaced as follows:

3-10.i.2 Medical Services Budget Target

(a) The CONTRACTOR shall submit a Medical Services Monitoring Report monthly with cumulative year to date calculation using the instructions in Attachment XII, Exhibit J in accordance with Section 2-10.j of this Agreement. From this report, TennCare will compute a quarterly Medical Services Budget Target. This will be established by computing the percent change for each quarter two years historically. A percent change will be computed for each quarter compared to the prior year quarter. This trend will be applied to the per member costs for previous year quarter to establish the Medical Services Budget Target for future quarters.

The MSBT will be evaluated in terms of the prior year quarter for the same timeframe (i.e. 3rd Qtr 2005 will be compared to 3rd Qtr 2004). The data from the Medical Services Budget Target quarterly update will be used to establish the quarterly PMPMs.

(b) Effective July 1, 2006, the MSBT Benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR prior to July 1, 2006.

(c) Effective July 1, 2007, the MSBT benchmark will be established on a regional basis by rate cell using historical claims data. Trends will be applied for utilization and adjustments for moderately management of care based on recommendations of actuaries contracted by the State.

26. Effective July 1, 2007, the Evaluation Period for Sections 3-10.i.3(a), (b), (d), (e), (f), and (g) shall be changed from "Quarterly" to "Annual" as described below. Section 3-10-i.3(c) shall not be amended.

3-10.i.3(a) Medical Services Budget Target Initiative

At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	**Administrative Fee Adjustment**
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 2% of Administrative Fee (Budget)
Implementation Date: July 1, 2007

3-10.i.3(b) Pharmacy Generic Use:

The Bureau will establish current generic trends for each MCO based on utilization data reported by the Pharmacy Benefits Manager (PBM).

This initiative targets the pharmacy generic use rates for the MCOs. TENNCARE shall establish a generic target for the MCO. Administrative fees will be adjusted based on deviations from the MCO generic use benchmark as listed below.

Percent of Generic Usage Target	**Administrative Fee Adjustment**
≥ 95%	All admin assoc with Generic Drug Usage at risk portion and potential bonus
< 95% and ≥ 90%	-25% of admin assoc Generic Drug Usage risk portion
< 90% and ≥ 85%	-50% of admin assoc Generic Drug Usage risk portion
< 85% and ≥ 80%	-75% of admin assoc Generic Drug Usage risk portion
< 80%	-100% of admin assoc Generic Drug Usage risk portion

Evaluation Period: Annual
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2007

3-10.i.3(d) ***Increase EPSDT Compliance***

The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Amended and restated Contractor Risk Agreement. Section 3-10.h.3(a) currently provides opportunity for the CONTRACTOR to receive a bonus for increasing EPSDT screening rates for the time period October 1, 2004 through September 30, 2005 only. The TennCare Program goal for EPSDT compliance is 80% and the CONTRACTOR shall make every effort to attain said goal. Effective July 1, 2006 a percentage of the administrative fee shall be placed at risk based on the CONTRACTOR's compliance with an EPSDT screening rate of 80%.

TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	**Administrative Fee Adjustment**
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2007

3-10.i.3(e) ***Non-Emergency ER Visits per 1000:***

TennCare will establish benchmarks for Non Emergency ER visits. Each MCO Non Emergency ER Visits/1000 benchmark will be derived from the Plan Cost and Utilization reports. TENNCARE shall provide the CONTRACTOR with a document which shall define Non-Emergency ER Visits for the purposes of reporting and documenting the achievement of this benchmark. Effective July 1, 2006, the ER Visits/1000 benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR.

Percentage of ER Visists/1000 (NE) Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with ER Visits per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc ER Visits per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc ER Visits per 1000 risk portion

> 115% and ≤ 120%	-75% of admin assoc ER Visits per 1000 risk portion
> 120% and greater	-100% of admin assoc ER Visits per 1000 risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2007

3-10.i.3(f) ***Inpatient Admissions per 1000:***

TennCare will establish benchmarks for Inpatient Admits/1000. Effective July 1, 2005 through June 30, 2006, each MCO Inpatient Admits/1000 benchmark will be derived from the Plan Cost and utilization reports. Effective July 1, 2006, the Inpatient Admits per 1000 benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR.

Percentage of Inpatient Admissions/1000 Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with Inpatient Admits per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc Inpatient Admits per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc Inpatient Admits per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc Inpatient Admits per 1000 risk portion
> 120% and greater	-100% of admin assoc Inpatient Admits per 1000 risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2007

3-10.i.3(g) ***Inpatient Days Per 1000***

TennCare will establish benchmarks for Inpatient Days per 1000 based on the CONTRACTOR's claims data and shall provide the benchmark to the CONTRACTOR prior to July 1, 2006.

Percentage of Inpatient Days per 1000 Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with Inpatient Days per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc Inpatient Days per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc Inpatient Days per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc Inpatient Days per 1000 risk portion
> 120% and greater	-100% of admin assoc Inpatient Days per 1000 risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2007

27. Section 3-10.i.4 shall be amended by adding a new sentence in the first paragraph and changing the Medical Services Budget Target Contribution to bonus from "5%" to "10%" in the following chart as follows:

3-10.i.4. Performance Bonuses

TennCare will establish a bonus pool for each Risk Initiative. The bonus pool will represent fifteen percent (15%) of the administrative fee for the CONTRACTOR as described in Attachment X. The following Initiatives will be included in the Bonus Pool: Medical Services Budget Target, Generic Usage, EPSDT Compliance, ER Visits/1000 (NE), and Inpatient Admits/1000. Effective July 1, 2006, Inpatient Days per 1000 shall be one of the initiatives included in the Bonus Pool. Effective July 1, 2007, the bonus pool will represent twenty percent (20%) of the administrative fee for the CONTRACTOR as described in Attachment X. The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus
Medical Services Budget Target	10.0%
Usage of Generic Drugs	2.0%
EPSDT Compliance	2.0%
ER Visits/1000 (NE)	2.0%
Inpatient Admits/1000	2.0%
Inpatient Days/1000	2.0%

28. Section 3-10.i.11 shall be deleted and replaced as follows:

3-10.i.11 Pay-for-Performance Quality Incentive

On July 1, 2007 the CONTRACTOR will be eligible for an additional $0.03 pmpm, applied to member months from the period of July 1, 2006 to December 31, 2006, if their HEDIS 2007 HbA1C testing rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS HbA1C testing rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the following table where the CONTRACTOR's 2006 HEDIS HbA1C testing rate represents the baseline.

NCQA Minimum Effect Size Change Requirements:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

In addition, on July 1, 2007, the CONTRACTOR will be eligible for another $0.03 pmpm applied to member months from the period of July 1, 2006 – December 31, 2006. This additional payment will be made if the CONTRACTOR's 2007 HEDIS Prenatal Care rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS Prenatal Care rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the table above where the MCO's 2006 HEDIS Prenatal Care rate represents the baseline.

On December 31, 2007, the CONTRACTOR will be eligible for an additional $0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for

asthma has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with asthma as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with asthma in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

In addition, on December 31, 2007, the CONTRACTOR will be eligible for an another $0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with congestive heart failure as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with congestive heart failure in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

On July 1, 2008, the CONTRACTOR will be eligible for a $0.03 pmpm payment, applied to member months from the period January 1, 2007 to December 31, 2007, for each of the following 2008 HEDIS or CAHPS measures for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology, where the applicable 2007 HEDIS or CAHPS score serves as the baseline.

- HbA1C Testing
- Controlling High Blood Pressure
- Timeliness of Prenatal Care
- Postpartum Care
- Adolescent Immunizations (combo2)
- Childhood Immunizations (combo 2)
- Cervical Cancer Screening

29. The Liquidated Damages Chart in Section 4-8.b.2 shall be amended by adding a new C.4 which shall read as follows:

C.4	Failure to reimburse the first MCO within thirty (30) calendar days of receipt of a properly documented request for a misaligned newborn in accordance with Section 2-6.a.12		$1000.00 per day for each day beyond thirty (30) calendar days of receipt of a properly documented request in addition to a one time assessment of $5,000 per occurrence

30. Section 4-28 shall be deleted and replaced as follows:

4-28. Term of the Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements except as stated in Section 1-7. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2008 unless the CONTRACTOR or the State complies with Section 4-2.(f)

regarding non-renewal or unless the State approves termination of the Agreement in accordance herewith. Said renewal shall be automatic and shall not require any notice or other action.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

UAHC ONLY

30. Section 4-28 shall be deleted and replaced as follows:

4-28. Term of the Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements except as stated in Section 1-7. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2007 unless the CONTRACTOR or the State complies with Section 4-2.(f) regarding non-renewal or unless the State approves termination of the Agreement in accordance herewith. Said renewal shall be automatic and shall not require any notice or other action.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

31. ATTACHMENT IV shall be deleted and replaced in its entirety and shall read as follows:

ATTACHMENT IV
SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

(1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics and Urology; and

(2) The following access standards are met:

- Travel distance does not exceed 60 miles for at least 75% of non-dual members and
- Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000

32. Attachment XII, Exhibit E shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".

ATTACHMENT XII, EXHIBIT E
LEFT BLANK INTENTIONALLY

33. ATTACHMENT XII, Exhibit H.1 "QIA Grid" shall be deleted in its entirety and shall read "LEFT BLANK INTENTIONALLY".

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2007 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

MCO NAME

BY: _____
Name
Title

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
John G. Morgan
Comptroller

DATE: _____